STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013005	A. BUILDING _____ B. WING _____	03/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARLINGTON PLACE HEALTH CAMPUS	1635 N ARLINGTON AVE INDIANAPOLIS, IN 46218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for an Initial Certification and State Licensure Survey. Survey dates: March 26 and 27, 2014. Facility number: 013005 Provider number: 013005 AIM number: N/A Survey team: Courtney Mujic, RN- TC Beth Walsh, RN Janelyn Kulik, RN (March 27, 2014) Census bed type: SNF: 3 Residential: 1 Total: 4 Census payor type: Other: 4 Total: 4 Sample: 3 Residential sample: 1 Arlington Place Health Campus was found to be in compliance with 42 CFR 483, Subpart B in regard to the Initial Certification and State Licensure Survey. Quality review completed on March 29, 2014, by Janelyn Kulik, RN.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.